COUNTY OF ORANGE, CA HEALTH CARE AGENCY
EMERGENCY MEDICAL SERVICES AGENCY
EMERGENCY INFORMATION FOR CHILDREN WITH SPECIAL NEEDS

Name_____ **Date form completed**_____ **Initials**_____

Home Address_____ **Revised**_____ **Initials**_____

_____ **Revised**_____ **Initials**_____

Emergency contacts **Birth date**_____

Name (relationship)/phone: **Home phone**_____

1._____ **2.** _____

Primary care physician_____ **Phone**_____ **Fax**_____

Specialty physician_____ **Phone**_____ **Fax**_____

Specialty physician_____ **Phone**_____ **Fax**_____

Anticipated Primary ED_____

DNR form completed: _____ **yes** _____ **no**

Diagnoses

1._____
2._____
3._____
4._____

Allergies

1._____
2._____
3._____
4._____

Synopsis

_____
_____
_____
_____

Medications

1._____ **2.**_____ **3.**_____
4._____ **5.**_____ **6.**_____

Significant baseline physical findings

_____
_____

Significant baseline ancillary findings (lab, radiography, ECG):

_____

Management data

Medications to be avoided **and why:**

1._____ _____
2._____ _____
3._____ _____

Procedures to be avoided **and why:**

1._____ _____
_____ _____
2._____ _____
3._____ _____

Antibiotic prophylaxis_____

Indication_____

Medication and dose:_____

_____

Common presenting problems/findings with specific suggested managements

Problem	**Suggested Diagnostic Studies**	**Suggested Treatment**

Comments on child, family, or other specific medical issues:

_____